Exhibit 1

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

MEDICAID SUPPLEMENTAL PAYMENT PROGRAM
CERTIFICATION OF HOSPITAL PARTICIPATION

TPI Number:

On behalf of , a privately owned and operated hospital licensed and in good standing under the laws of the State of Texas ("Hospital"), I, , affirm and certify the following:

1. ***Authorization.***

    a. Hospital is a party to an Indigent Care Affiliation Agreement ("Affiliation Agreement") that was entered into between ("Governmental Entity") and Hospital and/or a group of private hospitals that provide uncompensated care in the communities served by the Governmental Entity (the "Affiliated Hospitals").

    b. As a qualified private hospital that is affiliated with the Governmental Entity, Hospital receives supplemental Medicaid payments ("Supplemental Payments") from the Health and Human Services Commission ("HHSC") pursuant to either or both Section (z) of Attachment 4.19-A and Section (8) of Attachment 4.19-B of the Texas Medicaid State Plan and pursuant to the regulations at 1 Tex. Admin. Code. §355.8070 (the "Supplemental Payment Program").

2. ***Assurances and Representations.***

    a. *Validity of Claims.* All claims filed by Hospital for Supplemental Payments have complied and will comply with the applicable regulations regarding the Medicaid upper limit provisions at Title 42, Code of Federal Regulations, Part 447, sections 447.272 and 447.321.

b. *Use of Supplemental Payments*.

i. No funds derived from any Supplemental Payment received by Hospital have been or will be returned or reimbursed to the Local Governmental Entity.

ii. No other funds have been used to reimburse the Local Governmental Entity in consideration of any supplemental funds paid to Hospital.

iii. Hospital will not use any of the Supplemental Payments to fund any contingent fee arrangement or agreement or to pay for third-party consultant or legal services.

c. *Agreements with Governmental Entity*.

i. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition either the amount of the Public Funds transferred by the Governmental Entity or the amount of Medicaid supplemental payments Hospital receives on the amount of indigent care Hospital has provided or will provide;

ii. Hospital has not entered and will not enter into any agreement with the Governmental Entity to condition the amount of Hospital's indigent care obligation on either the amount of Public Funds transferred by the Governmental Entity to HHSC or the amount of Supplemental Payment Hospital may be eligible to receive;

iii. Neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has made or agreed to make cash or in-kind transfers to the Governmental Entity other than transfers and transactions that:

(1) Following the date this Certification was executed, are unrelated to the administration of the Supplemental Payment Program and/or the delivery of indigent care services under an affiliation agreement;

(2) Constitute fair market value for goods and/or services rendered or provided by the Governmental Entity to Hospital; and

(3) Represent independent, bona fide transactions negotiated at arms-length and in the ordinary course of business between Hospital and the Governmental Entity;

d. *Assignment/Assumption of Governmental Entity Obligations*.

i. Except as specified in paragraph 2.c.iii above, neither Hospital nor any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals has, following the date this Certification was executed:

(1) Taken assignment or agreed to take an assignment of a contractual or statutory obligation of the Governmental Entity; or

(2) Authorized or consented to the assumption of a statutory or contractual obligation of the Governmental Entity by an Affiliated Hospital or any other entity acting on behalf of an Affiliated Hospital or group of Affiliated Hospitals.

ii. In the event that Hospital had taken assignment of or assumed a contractual or statutory obligation of the Governmental Entity prior to the date of this Certification, Hospital will terminate the terms of such assignment or assumption no later than 120 calendar days after the date of this Certification.

e. *Use of Financial Mechanisms.* With regard to any escrow, trust or other financial mechanism (an "Account") utilized in connection with an indigent care affiliation agreement or an IGT issued for a payment period that occurs after the effective date of this Certification, the following representations are true and correct:

i. The amount of any Account is not conditioned or contingent on the amount of indigent care services that an Affiliated Hospital provided or will provide;

ii. The Governmental Entity has disclosed the existence of any Account to HHSC; and

iii. Any such Account will not be used to affect a quid pro quo for the provision of indigent care services by or on behalf of the Affiliated Hospitals.

3. ***Deferral or Disallowance of Federal Financial Participation.***

a. If the Centers for Medicare and Medicaid Services ("CMS") of the United States Department of Health and Human Services or any other lawful authority disallows, defers, or otherwise rejects, in whole or in part, a claim for federal financial participation based on a claim submitted by Hospital to HHSC for health care services provided under the Affiliation Agreement, HHSC will have the right, by set-off or recoupment, to recover the amount disallowed, deferred, or rejected by CMS, subject to Hospital's rights of administrative appeal.

b. The set-off and/or recoupment may include any interest, fees, or sanctions assessed by CMS as a result of late repayment to CMS.

4. ***Public Access to Affiliation Agreement.*** Copies of the Affiliation Agreement shall be made available as provided under the Public Information Act (Chapter 552, Government Code) and will be provided to HHSC on request.

On behalf of Hospital, I hereby certify that I have read and understood the above statements; that the statements are true, correct, and complete; and that I am authorized to bind Hospital, and to certify to the above.

_____ _____

Signature Date

_____

Name and Title (print or type)